Exhibit 16

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
HUNTINGTON DIVISION

Jonathan R., minor, by Next Friend, Sarah Dixon, et al.,	:	
Plaintiffs,	:	Class Action
v.	:	3:19-cv-00710
Jim Justice, in his official capacity as the Governor of West Virginia, et al.,	:	
Defendants.	:	

VIDEOCONFERENCE DEPOSITION OF SUSAN GETMAN

DATE: October 15, 2020
TIME: 9:02 a.m. to 2:01 p.m.
LOCATION: Witness Location

REPORTED BY: Felicia A. Newland, CSR

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organizations, so -- and I would say that in some cases, while there are interviews in the process of a review, an audit is a very specific term, so if I'm not bound by the language of audit --

Q You're not bound by the language of audit.

A Yeah, because that's a whole -- that's a whole other kind of review.

The case records can be reviewed, and there may be interviews, but not about the case. So I think it's important to differentiate that.

So, for instance, you could come in and have someone review cases and then interview staff about what is it like to be a staff person there and what are the HR policies and what's the culture. And so one would need to be careful. And that's why I'm not going to kind of put a hard stake in the ground on this, because there are procedures around accreditations, for instance, that, of course, has lots of interviews, but they aren't necessarily regarding the cases, per se, that are reviewed as a component and as a section

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of that overall process.

Q Well, let's talk a little bit about the case records and then, in particular, the format in which up had to review them, which if I am reading the report correctly, there was some frustration with how the records were organized. Was that your experience?

A Yes.

Q And what's your understanding of how the records are -- those records would actually be accessed by West Virginia caseworkers?

MS. LOWRY: Objection.

THE WITNESS: I wouldn't have a way of knowing that.

BY MS. BROWN:

Q Do you -- is it your understanding that they are also looking at screenshots?

MS. LOWRY: Objection.

THE WITNESS: No.

BY MS. BROWN:

Q Do you think that the manner in which you had to review the case records affected your

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analysis of what occurred in a particular case?

A No. I think it affected the amount of time it took to get there, but I don't think it affected the conclusion.

Q And there were a number of instances in which you noted that there was not documentation of something. Is that correct?

A That is correct.

Q And are those circumstances where it would have been helpful to talk to a caseworker or a family or a child to try to fill in those gaps?

A It would have helped -- been helpful to have a document.

Q Helpful to have the document or helpful to have the information?

A The information that would have been contained in the document.

Q Is it your opinion that all information must be set forth in the document?

A It is my belief and my training that if something is not written in a case record, one cannot assume that it happened. And that's a

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pretty standard, you know, if it's not written, it didn't happen, kind of standard.

Q And so that's the conclusion, if it didn't -- if it's not written, it didn't happen, or if it's not written, I need to find out if it happened?

A I had the case record solely accessible to me. That's what I had. I looked and I looked for things and there were places that it would say, "See file cabinet."

Q Do you know what the file cabinet is?

A I do not.

Q Did you ask what it is?

A Yes, I did.

Q And did you get an answer?

MS. LOWRY: Objection.

THE WITNESS: I just want to make sure her objection was noted.

BY MS. BROWN:

Q Yeah.

A Our understanding was that we were given everything that there was that was available.

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recalled it. I don't recall.
Q Okay. Would you describe the three children whose case records you looked at as relatively easy or relatively complicated cases?
MS. LOWRY: Objection.
THE WITNESS: Can I get out of this exhibit?
BY MS. BROWN:
Q Yes. Yeah, you can close it. And I don't think I'm going to have another one.
A All right. So I can close Exhibit Share entirely?
Q Well, why don't you minimize it. I don't think I'll have another exhibit.
A Okay. Let's see here. Okay. Sorry, I just -- I'm not a technical person, so I didn't want to disconnect you.
Q Believe me, why do you think I am having Julie do everything. I feel your pain.
So my question was: Would you describe the three children whose case records you looked as relatively easy or relatively complicated

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cases?
MS. LOWRY: And I objected.
THE WITNESS: I think that at the onset, they were pretty typical cases. They are the kind children in family situations that come to the attention of a Child Protective Service agency. I think they didn't need to become so complicated. I think they did become more complicated as time went on because multiple placements are trauma events for children.
All of these children had multiple traumas before they came into care. So with each placement and the way in which the placements occurred, additional traumas were heaped on and their behaviors certainly reflected the trauma that they were experiencing and the dislocation they were experiencing.
So I guess my answer is both. Right? You know, that I think these were pretty typical kinds of cases. There wasn't anything highly unusual at the outset of these cases.

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BY MS. BROWN:
Q How about from the time that they came into care, putting aside the pre-placement investigation time period?
A Uh-huh. Well, let me stop and think. I don't think my answer would change. I think that for each of these children, when they came into care, you know, that initial placement is a crisis. The details obviously vary between the three, but I think as children coming into care, again, I think they evidence sort of typical worries and concerns and behaviors that with appropriate services and supports could have been managed such that they didn't need to become escalated behaviors, multiple placements, et cetera.
Q What evaluation did you do to determine if the three cases you looked at had common issues with all foster children in West Virginia?
MS. LOWRY: Objection.
THE WITNESS: I have -- I don't have access to that kind of information.

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BY MS. BROWN:
Q Turning to the executive summary. What was the process for putting that together?
A The three expert witnesses collaborated on it because it needed to be an executive summary of all nine. So there was no single author. We each took different sections. And in the end, I assumed responsibility for making sure there was coherence and a good flow and that sort of thing.
But there were, by my recollection, eight sections. And each of us had responsibility for doing the initial drafting and then each of us had responsibility for contributing to each other's sections. And part of the contribution was case examples, examples from the children that we reviewed that we thought were good examples of the dynamic that was being discussed.
Q So did you -- did you first discuss the case examples or did you first draft the -- your different sections?
A So the very first thing we did was

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that we really thought would benefit from sort of taking a look at as an area for improvement.
Q So I don't think it says, we think that this is something that requires more inquiry.
A Let me get to that. If you want me to find the place, I will just need a few minutes.
Q Yeah. The paragraph is on page 30.
A Yeah, I think this is couched in, you know, if you have certain elements in place in a culture, in an organizational culture, then you would expect to see the consistency of practice, you would expect to see some things that we did not.
Q In these nine case?
A In these nine cases.
Q But you didn't speak to any supervisors and any caseworkers and you didn't review any training materials, correct?
A Yes. You've asked that. Correct.
Q So is this a conclusion as to organizational culture or it's a, "I would like to know more about the organizational culture"

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statement?
A This is a statement that there was not evidence of the kinds of resources and cultural practices that would reasonably expect to avoid some of the problems that we saw.
Q That's what this paragraph is intended to say?
A Yes. It's not explicit, you're right. We didn't review a binder of training materials that was empty. We saw a practice that we felt was reflective of the need for more supports.
Q Turning to the second concern. "The case record failed to be an effective case management tool, neither containing a coherent history, nor serving to support critical thinking interventions and planning."
I think I have already asked this and you already answered it, but that is based on your review of the documents as they came to you, not your understanding of how they may be accessed in real -- in their native state by the caseworkers

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and supervisors. Is that right?
A The only thing we had to form an opinion on was what we were given.
Q And the third item that is noted as a systemic concern is, "The knowledge and skill of frontline workers and supervisors"?
A Uh-huh.
Q What do you mean by that?
A We mean that -- and I will say "we," this was jointly written -- this wasn't the section that I wrote, but I did review, is that there are --
Q You reviewed and it's your sworn testimony, correct?
A Yeah, no, I -- I'm just saying I'm using the pronoun "we" as opposed to "I."
There were repeated examples of where I would have expected a social worker charged with the safety and well-being of a child to have more knowledge about family dynamics, more knowledge about interviewing and motivational interviewing, more knowledge about child development and why a

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child might change their story, more knowledge about sexual victimization. And that was just really repeatedly absent in the case notes and in the actions and in the planning of the cases that I reviewed.
Q You don't actually know what their knowledge is, you know what was put into the case record. Is that right?
A No, I don't think that's what I mean. How can anyone know what one's knowledge is except through one's behavior. And the behavior, the professional behavior and practice -- and I'm not going to use the word "conduct," because that sounds more personal to the individual, but their behavior, their practice, had they had knowledge of child development, trauma, family dynamics, substance abuse, it is reasonable to assume that that knowledge would have been reflected in a different professional behavior than what was evident in case notes written by these individuals, and in the actions that they took when confronted with a situation.

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Q So earlier we spoke about some actions that Garrett's caseworker took with respect Garrett, advocacy to get him into a program that she thought was appropriate for him. Do you believe that that case record from that caseworker reflected a lack of knowledge and skill, failure to understand Garrett?

A Actually, I will say two things about that example. One is this woman went above and beyond in advocating for him, it is true. She, by her own writing, says that she believed he needed another chance, that he had skills, that he should have a chance to express and to take on -- to be nurtured in that way.

One could say, and there was no point in me going into it at the time, that such advocacy, while, well placed and well meaning and heartfelt, was also naive. He lasted less than a week in the placement. And the amount of freedom, which she so desperately wanted him to be able to use productively, was well beyond his ability at that point in his -- his life experience to manage.

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And she later went back to him and said she felt he had used her, that he had set her up.

Now, you know, I -- it is far beyond the extent of this review to say, you know, should she have known? Might she have had a supervisor that said, "Hey, I hear that you really want to go to bat for this kid and really want the best for him, but let's take a look at the history. Let's take a look at how he has dealt with things. Is he really ready for this?"

Q Should he be in a more restrictive setting?

A Should he be in a different setting. That was -- I wouldn't put it in restrictive and not restrictive. I think that the place that he was -- now, mind you, this is after years and years of being in placements and not getting out of placements when he was ready to be discharged and when the residential providers were ready to discharge him, but there was no -- no place for them to go. DHHR did not have a discharge placement and he decompensated. So yes, at that

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point he needed a different kind of placement than what this particular placement was.

And I -- I would, thinking back at her case notes, I don't recall her talking with other people. I don't recall her having a supervisor who said, you know, "Can we think about this? Can we think about what other supports he's going to need in order to be successful there?"

She was a new worker to him at the time and she really did -- she didn't take no for an answer and really advocated admirably for him, but perhaps not with all the information that was needed.

Q Is it a reasonable professional standard to note in a case record when there has been a discussion between two caseworkers or a caseworker and a supervisor?

A Around key decisions, it is not uncommon.

Q Is it required as a matter of standard practice?

A Well, required varies from

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jurisdiction to jurisdiction. So there's some jurisdictions -- apparently New York being one -- that the supervisors are expected to make entries actually into the record. Not all jurisdictions have that, so I can't answer the question.

Q Do you know of any other jurisdiction that operates like New York?

A I don't. I do know that other jurisdictions have -- have meetings in which supervisors are present and the attendance at those meetings is noted in the record.

Q There's no reason it has to be noted in the record, however, as long as the meeting takes place?

MS. LOWRY: Objection.

THE WITNESS: It depends on the jurisdiction and their policies.

BY MS. BROWN:

Q Just to confirm the comments on the organizational culture of DHHR is based mostly on what's not in the record, not what is. Is that correct?